REFERENCE G: REMITTANCE ADVICE (RA) REMARK CODES

(Last Updated 2/1/2004)

Please note that all information listed below was accurate per the Centers for Medicare & Medicaid Services (CMS) website at the time of printing; however, this information is subject to change.

The RA remark code list is updated three times per year. The most recent list can be access at http://www.wpc-edi.com/codes/Codes.asp on the Web.

GENERAL INFORMATION

Any remark code may now be reported at the service or the claim level, as applicable, in any electronic or paper remittance advice version.

Rather than renumber existing M (prior service level) and MA (prior claim level) codes, and possibly confuse providers, "old" code numbers have been retained. All new post-consolidation remark codes, however, will begin with an N. The "N" is used to quickly differentiate remark codes from claim adjustment reason codes. Remark codes that apply at the service level must be reported in the X12 835 LQ segment. Remark codes that apply to an entire claim must be reported in the X12 835 MIA (inpatient) or MOA (non-inpatient) segment, as applicable.

REMARK CODES

Note: For the purpose of using these codes, the terms "you" and "your" refer to the provider, and the terms "us" and "we" refer to Medicare.

A new or modified code is effective and can be used by a provider as soon as the revised list is published. A deactivation becomes effective six months after the scheduled publication date of the code list.

Code	Description	Notes
M1	X-ray not taken within the past 12 months or near enough to the start of treatment.	
M2	Not paid separately when the patient is an inpatient.	
M3	Equipment is the same or similar to equipment already being used.	
M4	This is the last monthly installment payment for this Durable Medical Equipment (DME).	
M5	Monthly rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.	
M6	You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for every 6 month period after the end of the 15th paid rental month or the end of the warranty period.	
M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.	

Code	Description	Notes
M8	We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.	
M9	This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement.	
M10	Equipment purchases are limited to the first or the tenth month of medical necessity.	
M11	DME, orthotics and prosthetics must be billed to the DME carrier who services the patient's ZIP Code.	
M12	Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.	
M13	No more than one initial visit may be covered per specialty per medical group. Visit may be rebilled with an established visit code.	Modified 6/30/03.
M14	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.	
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	
M16	Please see the letter or bulletin (date) for further information.	Deactivated effective 1/31/04.
M17	Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.	
M18	Certain services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home.	Modified 6/30/03.
M19	Missing/incomplete/invalid oxygen certification/re-certification.	Modified 2/28/03.
M20	Missing/incomplete/invalid HCPCS.	Modified 2/28/03.
M21	Missing/incomplete/invalid place of residence for this service/item provided in a home.	Modified 2/28/03.
M22	Missing/incomplete/invalid number of miles traveled.	Modified 2/28/03.
M23	Invoice needed for the cost of the material or contrast agent.	
M24	Missing/incomplete/invalid number of doses per vial.	Modified 2/28/03.

Code	Description	Notes
M25	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this (more extensive) service, or if you notified the patient in writing in advance that we would not pay for this (more extensive) service and he/she agreed in writing to pay, ask us to review the claim within 120 days of the date of this notice. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her (for the/in excess of any deductible and coinsurance amounts applicable to the less extensive) service. We will recover the reimbursement from you as an overpayment.	Modified 10/1/02, 6/30/03.
M26	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to the refund requirement in two cases: ❖ If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or ❖ If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request review at any time within 120 days of the date of this notice. However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a	Modified 10/1/02, 6/30/03.

Code	Description	Notes
M26 (con't)	review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days. The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. Please contact this office if you have any questions about this notice.	
M27	The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. This determination may be appealed provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal. You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 120 days of the date of this notice (or, for a medical insurance review, within 120 days of the date of this notice). The request can be made through any Social Security office.	Modified 10/1/02.
M28	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.	
M29	Missing/incomplete/invalid operative report.	Modified 2/28/03.
M30	Missing/incomplete/invalid pathology report.	Modified 2/28/03.
M31	Missing/incomplete/invalid radiology report.	Modified 2/28/03.

Code	Description	Notes
M32	This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.	
M33	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.	Modified 2/28/03. Deactivated effective 8/1/04. Use M68.
M34	Claim lacks the CLIA certification number.	Deactivated effective 8/1/04. Use MA120.
M35	Missing/incomplete/invalid pre-operative photos or visual field results.	Modified 2/28/03.
M36	This is the 11th rental month. We cannot pay for this until you indicate that the patient has been given the option of changing the rental to a purchase.	
M37	Service not covered when the patient is under age 35.	
M38	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.	
M39	The patient is not liable for payment for this service as the advance notice of noncoverage you provided the patient did not comply with program requirements.	Modified 2/1/04.
M40	Claim must be assigned and must be filed by the practitioner's employer.	
M41	We do not pay for this as the patient has no legal obligation to pay for this.	
M42	The medical necessity form must be personally signed by the attending physician.	
M43	Payment for this service previously issued to you or another provider by another carrier/Intermediary.	Deactivated effective 1/31/04. Use M23.
M44	Missing/incomplete/invalid condition code.	Modified 2/28/03.
M45	Missing/incomplete/invalid occurrence codes or dates.	Modified 2/28/03.
M46	Missing/incomplete/invalid occurrence span code or dates.	Modified 2/28/03.
M47	Missing/incomplete/invalid internal or document control number.	Modified 2/28/03.
M48	Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.	Deactivated effective 1/31/04. Use M97.
M49	Missing/incomplete/invalid value code(s) or amount(s).	Modified 2/28/03.
M50	Missing/incomplete/invalid revenue code(s).	Modified 2/28/03.
M51	Missing/incomplete/invalid procedure code(s) and/or rates.	Modified 2/28/03, 2/1/04.

Code	Description	Notes
M52	Missing/incomplete/invalid “from” date(s) of service.	Modified 2/28/03.
M53	Missing/incomplete/invalid days or units of service.	Modified 2/28/03.
M54	Missing/incomplete/invalid total charges.	Modified 2/28/03.
M55	Medicare does not pay for self-administered anti-emetic drugs that are not administered with a covered oral anti-cancer drug.	
M56	Missing/incomplete/invalid payer identifier.	Modified 2/28/03.
M57	Missing/incomplete/invalid provider identifier.	Modified 2/28/03.
M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	Modified 2/28/03.
M59	Missing/incomplete/invalid “to” date(s) of service.	Modified 2/28/03.
M60	Missing/incomplete/invalid Certificate of Medical Necessity.	Modified 6/30/03.
M61	We cannot pay for this as the approval period for the FDA clinical trial has expired.	
M62	Missing/incomplete/invalid treatment authorization code.	Modified 2/28/03.
M63	We do not pay for more than one of these on the same day.	Deactivated effective 1/31/04. Use M86.
M64	Missing/incomplete/invalid other diagnosis.	Modified 2/28/03.
M65	One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indicated. You should submit a separate claim for each interpreting physician.	
M66	Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items.	
M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).	Modified 2/28/03.
M68	Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.	Modified 2/28/03, 2/1/04.
M69	Paid at the regular rate as you did not submit documentation to justify the modified procedure code.	Modified 2/1/04.
M70	NDC code submitted for this service was translated to an HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	
M71	Total payment reduced due to overlap of tests billed.	
M72	Did not enter full 8-digit date (MM|DD|YYYY).	Deactivated effective 10/16/2003. Use MA52.
M73	The HPSA bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components. Use the HPSA modifier on the professional component only.	
M74	This service does not qualify for a HPSA bonus payment.	
M75	Allowed amount adjusted. Multiple automated multichannel tests performed on the same day combined for payment.	

Code	Description	Notes
M76	Missing/incomplete/invalid diagnosis or condition.	Modified 2/28/03.
M77	Missing/incomplete/invalid place of service.	Modified 2/28/03.
M78	Missing/incomplete/invalid HCPCS modifier.	Modified 2/28/03.
M79	Missing/incomplete/invalid charge.	Modified 2/28/03.
M80	Not covered when performed during the same session/date as a previously processed service for the patient.	Modified 10/31/02.
M81	You are required to code to the highest level of specificity.	Modified 2/1/04.
M82	Service is not covered when patient is under age 50.	
M83	Service is not covered unless the patient is classified as at high risk.	
M84	Medical code sets used must be the codes in effect at the time of service.	Modified 2/1/04.
M85	Subjected to review of physician evaluation and management services.	
M86	Service denied because payment already made for same/similar procedure within set time frame.	Modified 6/30/03.
M87	Claim/service(s) subjected to CFO-CAP prepayment review.	
M88	We cannot pay for laboratory tests unless billed by the laboratory that did the work.	Deactivated effective 8/1/04. Use Reason Code B20.
M89	Not covered more than once under age 40.	
M90	Not covered more than once in a 12 month period.	
M91	Laboratory procedures with different CLIA certification numbers must be billed on separate claims.	
M92	Services subjected to review under the Home Health Medical Review Initiative.	Deactivated effective 8/1/04.
M93	Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment.	
M94	Information supplied does not support a break in therapy. A new capped rental period will not begin.	
M95	Services subjected to Home Health Initiative medical review/cost report audit.	
M96	The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.	
M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.	
M98	Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.	Deactivated effective 1/31/04. Use M99.

Code	Description	Notes
M99	Missing/incomplete/invalid Universal Product Number/Serial Number.	Modified 2/28/03.
M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.	
M101	Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.	Deactivated effective 1/31/04. Use M78.
M102	Service not performed on equipment approved by the FDA for this purpose.	
M103	Information supplied supports a break in therapy. However, the medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.	
M104	Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the fee schedule for this item or service.	
M105	Information supplied does not support a break in therapy. The medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will not begin.	
M106	Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service.	Deactivated effective 1/31/2004. Use MA31.
M107	Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.	
M108	Missing/incomplete/invalid provider identifier for the provider who interpreted the diagnostic test.	Modified 2/28/03.
M109	We have provided you with a bundled payment for a teleconsultation. You must send 25% of the teleconsultation payment to the referring practitioner.	
M110	Missing/incomplete/invalid provider identifier for the provider from whom you purchased interpretation services.	Modified 2/28/03.
M111	We do not pay for chiropractic manipulative treatment when the patient refuses to have an X-ray taken.	
M112	The approved amount is based on the maximum allowance for this item under the DMEPOS Competitive Bidding Demonstration.	
M113	Our records indicate that this patient began using this service(s) prior to the current round of the DMEPOS Competitive Bidding Demonstration. Therefore, the approved amount is based on the allowance in effect prior to this round of bidding for this item.	

Code	Description	Notes
M114	This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, phone 1-888-289-0710.	
M115	This item is denied when provided to this patient by a non-demonstration supplier.	
M116	Paid under the Competitive Bidding Demonstration. Project is ending, and future services may not be paid under this project.	Modified 2/1/04.
M117	Not covered unless submitted via electronic claim.	Modified 6/30/03.
M118	Letter to follow containing further information.	
M119	Missing/incomplete/invalid National Drug Code (NDC).	Modified 2/28/03.
M120	Missing/incomplete/invalid provider identifier for the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement.	Modified 2/28/03.
M121	We pay for this service only when performed with a covered cryosurgical ablation.	
M122	Missing/incomplete/invalid level of subluxation.	Modified 2/28/03.
M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	Modified 2/28/03.
M124	Missing/incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.	Modified 2/28/03.
M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.	Modified 2/28/03.
M126	Missing/incomplete/invalid individual lab codes included in the test.	Modified 2/28/03.
M127	Missing/incomplete/invalid patient medical record for this service.	Modified 2/28/03.
M128	Missing/incomplete/invalid date of the patient's last physician visit.	Modified 2/28/03.
M129	Missing/incomplete/invalid indicator of X-ray availability for review.	Modified 2/28/03, 6/30/03.
M130	Missing/incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.	Modified 2/28/03.
M131	Missing/incomplete/invalid physician financial relationship form.	Modified 2/28/03.
M132	Missing/incomplete/invalid pacemaker registration form.	Modified 2/28/03.
M133	Claim did not identify who performed the purchased diagnostic test or the amount that was charged for the test.	
M134	Performed by a facility/supplier in which the provider has a financial interest.	Modified 6/30/03.
M135	Missing/incomplete/invalid plan of treatment.	Modified 2/28/03.
M136	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.	Modified 2/28/03.
M137	Part B coinsurance under a demonstration project.	

Code	Description	Notes
M138	Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.	
M139	Denied services exceed the coverage limit for the demonstration.	
M140	Service not covered until after the patient's 50th birthday (i.e., no coverage prior to the day after the 50th birthday).	Deactivated effective 1/31/04. Use M82.
M141	Missing/incomplete/invalid physician certified plan of care.	Modified 2/28/03.
M142	Missing/incomplete/invalid American Diabetes Association Certificate of Recognition.	Modified 2/28/03.
M143	We have no record that you are licensed to dispensed drugs in the State where located.	
M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	
MA01	If you do not agree with what we approved for these services, you may appeal the decision. To make sure that we are fair to you, we require another individual that did not process you initial claim to conduct the review. However, in order to be eligible for a review, you must write to Medicare within 120 days of the date of this notice, unless you have a good reason for being late. An institutional provider (e.g., hospital, SNF, HHA or hospice) may appeal only if the claim involves a reasonable and necessary denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal. If your carrier issues telephone review decisions, a professional provider should phone the carrier's office for a telephone review if the criteria for a telephone review are met.	Modified 10/31/02, 6/30/03.
MA02	If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision. An institutional provider (e.g., hospital, SNF, HHA or a hospice) may appeal only if the claim involves a reasonable and necessary denial, a SNF non-certified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial	Modified 10/31/02, 6/30/03.

Code	Description	Notes
MA02 (con't)	because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.	
MA03	If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you have received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision. An institutional provider (e.g., hospital, SNF, HHA or a hospice) may appeal only if the claim involves a reasonable and necessary denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal.	
MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	
MA05	Incorrect admission date patient status or type of bill entry on claim.	Deactivated effective 10/16/2003. Use MA30 or MA40 or MA43.
MA06	Missing/incomplete/invalid beginning and/or ending date(s).	Modified 2/28/03. Deactivated effective 8/1/04. Use MA31.
MA07	The claim information has also been forwarded to Medicaid for review.	
MA08	You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.	
MA09	Claim submitted as unassigned but processed as assigned. You must agree to accept assignment for all claims.	
MA10	The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.	
MA11	Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due to Medicare. Please contact Medicare if the patient is covered by any of these sources.	Deactivated effective 1/31/04. Use M32.

Code	Description	Notes
MA12	You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).	
MA13	You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.	
MA14	Patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	
MA15	The claim has been separated to expedite handling. You will receive a separate notice for the other services reported.	
MA16	The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.	
MA17	We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.	
MA18	The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.	
MA19	Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit the secondary claim directly to that insurer.	
MA20	Skilled Nursing Facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.	Modified 6/30/03.
MA21	SSA records indicate mismatch with name and sex.	
MA22	Payment of less than $1.00 suppressed.	
MA23	Demand bill approved as result of medical review.	
MA24	Christian Science Sanitarium/Skilled Nursing Facility (SNF) bill in the same benefit period.	Modified 6/30/03.
MA25	A patient may not elect to change a hospice provider more than once in a benefit period.	
MA26	Our records indicate that you were previously informed of this rule.	
MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.	Modified 2/28/03.
MA28	Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.	
MA29	Missing/incomplete/invalid provider name, city, state, or ZIP Code.	Modified 2/28/03.

Code	Description	Notes
MA30	Missing/incomplete/invalid type of bill.	Modified 2/28/03.
MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	Modified 2/28/03.
MA32	Missing/incomplete/invalid number of covered days during the billing period.	Modified 2/28/03.
MA33	Missing/incomplete/invalid noncovered days during the billing period.	Modified 2/28/03.
MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.	Modified 2/28/03.
MA35	Missing/incomplete/invalid number of lifetime reserve days.	Modified 2/28/03.
MA36	Missing/incomplete/invalid patient name.	Modified 2/28/03.
MA37	Missing/incomplete/invalid patient's address.	Modified 2/28/03.
MA38	Missing/incomplete/invalid birth date.	Modified 2/28/03.
MA39	Missing/incomplete/invalid gender.	Modified 2/28/03.
MA40	Missing/incomplete/invalid admission date.	Modified 2/28/03.
MA41	Missing/incomplete/invalid admission type.	Modified 2/28/03.
MA42	Missing/incomplete/invalid admission source.	Modified 2/28/03.
MA43	Missing/incomplete/invalid patient status.	Modified 2/28/03.
MA44	No appeal rights. Adjudicative decision based on law.	
MA45	As previously advised, a portion or all of your payment is being held in a special account.	
MA46	The new information was considered, however, additional payment cannot be issued. Please review the information listed for the explanation.	
MA47	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment.	
MA48	Missing/incomplete/invalid name or address of responsible party or primary payer.	Modified 2/28/03.
MA49	Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services.	Modified 2/28/03. Deactivated effective 8/1/04. Use MA76.
MA50	Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.	Modified 2/28/03.
MA51	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.	Modified 2/28/03.
MA52	Missing/incomplete/invalid date.	Modified 2/28/03.
MA53	Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.	Modified 2/1/04.
MA54	Physician certification or election consent for hospice care not received timely.	

Code	Description	Notes
MA55	Not covered as patient received medical healthcare services, automatically revoking his/her election to receive religious non-medical health care services.	
MA56	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.	
MA57	Patient submitted written request to revoke his/her election for religious non-medical health care services.	
MA58	Missing/incomplete/invalid release of information indicator.	Modified 2/28/03.
MA59	The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.	
MA60	Missing/incomplete/invalid patient relationship to insured.	Modified 2/28/03.
MA61	Missing/incomplete/invalid social security number or health insurance claim number.	Modified 2/28/03.
MA62	Telephone review decision.	
MA63	Missing/incomplete/invalid principal diagnosis.	Modified 2/28/03.
MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	
MA65	Missing/incomplete/invalid admitting diagnosis.	Modified 2/28/03.
MA66	Missing/incomplete/invalid principal procedure code or date.	Modified 2/28/03.
MA67	Correction to a prior claim.	
MA68	We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PLANID of the insurer to assure correct and timely routing of the claim.	
MA69	Missing/incomplete/invalid remarks.	Modified 2/28/03.
MA70	Missing/incomplete/invalid provider representative signature.	Modified 2/28/03.
MA71	Missing/incomplete/invalid provider representative signature date.	Modified 2/28/03.
MA72	The patient overpaid you for these assigned services. You must issue the patient a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the patient on this notice.	
MA73	Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.	
MA74	This payment replaces an earlier payment for this claim that was either lost, damaged or returned.	
MA75	Missing/incomplete/invalid patient or authorized representative signature.	Modified 2/28/03.

Code	Description	Notes
MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.	Modified 2/28/03, 2/1/04.
MA77	The patient overpaid you and you must issue the patient a refund within 30 days for the difference between the patient's payment less the total of our and other payer payments and the amount shown as patient responsibility on this notice.	
MA78	The patient overpaid you. You must issue the patient refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.	Deactivated effective 1/31/04. Use MA59.
MA79	Billed in excess of interim rate.	
MA80	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its Intermediary for all services for this encounter under a demonstration project.	
MA81	Missing/incomplete/invalid provider/supplier signature.	Modified 2/28/03.
MA82	Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, ZIP code, or phone number.	Modified 2/28/03.
MA83	Did not indicate whether Medicare is the primary or secondary payer. Refer to the instructions for Block 11 of Form CMS-1500 for assistance.	
MA84	Patient identified as participating in the National Emphysema Treatment Trial but Medicare records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.	
MA85	Medicare records indicate that a primary payer exists (other than Medicare); however, the provider did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.	Deactivated effective 1/31/04. Use MA59.
MA86	Missing/incomplete/invalid group or policy number of the insured for the primary coverage.	Modified 2/28/03. Deactivated effective 8/1/04 Use MA92.
MA87	Missing/incomplete/invalid insured's name for the primary payer.	Modified 2/28/03. Deactivated effective 8/1/04. Use MA92.
MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.	Modified 2/28/03.
MA89	Missing/incomplete/invalid patient's relationship to the insured for the primary payer.	Modified 2/28/03.
MA90	Missing/incomplete/invalid employment status code for the primary insured.	Modified 2/28/03.
MA91	This determination is the result of the appeal filed by the provider.	
MA92	Missing/incomplete/invalid primary insurance information.	Modified 2/28/03, 2/1/04.

Code	Description	Notes
MA93	Non-Periodic Interim Payment (PIP) claim.	Modified 6/30/03.
MA94	Did not enter the statement “Attending physician not hospice employee” on the claim to certify that the rendering physician is not an employee of the hospice. Refer to Block 19 on Form CMS-1500.	Deactivated effective 1/31/04. No field on 837.
MA95	De-activate and refer to M51.	Modified 2/28/03.
MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	
MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number.	
MA98	Claim Rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.	Deactivated effective 10/16/2003. Use MA97.
MA99	Missing/incomplete/invalid Medigap information.	Modified 2/28/03.
MA100	Missing/incomplete/invalid date of current illness, injury or pregnancy.	Modified 2/28/03.
MA101	A SNF is responsible for payment of outside providers who furnish these services/supplies to residents.	
MA102	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider.	Modified 2/28/03. Deactivated effective 8/1/04. Use M68.
MA103	Hemophilia Add On.	
MA104	Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician.	Deactivated effective 1/31/04. Use M128 or M57.
MA105	Missing/incomplete/invalid provider number for this place of service.	Modified 2/28/03.
MA106	PIP (Periodic Interim Payment) claim.	Modified 6/30/03.
MA107	Paper claim contains more than three separate data items in field 19.	
MA108	Paper claim contains more than one data item in field 23.	
MA109	Claim processed in accordance with ambulatory surgical guidelines.	
MA110	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.	Modified 2/28/03.
MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.	Modified 2/28/03.
MA112	Missing/incomplete/invalid group practice information.	Modified 2/28/03.

Code	Description	Notes
MA113	Incomplete/invalid taxpayer identification number (TIN) submitted by the provider per the Internal Revenue Service. The providers claims cannot be processed without the correct TIN, and the provider may not bill the patient pending correction of their TIN. There are no appeal rights for unprocessable claims, but the provider may resubmit this claim after notifying Medicare of their correct TIN.	
MA114	Missing/incomplete/invalid information on where the services were furnished.	Modified 2/28/03.
MA115	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).	Modified 2/28/03.
MA116	Did not complete the statement “Homebound” on the claim to validate whether laboratory services were performed at home or in an institution.	Deactivated effective 1/31/04. No field in 837 for this statement.
MA117	This claim has been assessed a $1.00 user fee.	
MA118	Coinsurance and/or deductible amounts apply to a claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. No Medicare payment issued.	
MA119	Provider level adjustment for late claim filing applies to this claim.	
MA120	Missing/incomplete/invalid CLIA certification number.	Modified 2/28/03.
MA121	Missing/incomplete/invalid date the X-ray was performed.	Modified 2/28/03, 6/30/03, 2/1/04.
MA122	Missing/incomplete/invalid initial date actual treatment occurred.	Modified 2/28/03.
MA123	Your center was not selected to participate in this study, therefore, Medicare cannot pay for these services.	
MA124	Processed for IME only.	Deactivated effective 1/31/04. Use Reason Code 74.
MA125	Per legislation governing this program, payment constitutes payment in full.	
MA126	Pancreas transplant not covered unless kidney transplant performed.	New Code 10/12/01.
MA127	Reserved for future use.	
MA128	Missing/incomplete/invalid six-digit FDA-approved, identification number.	Modified 2/28/03.
MA129	This provider was not certified for this procedure on this date of service.	Deactivated effective 1/31/04. Refer to MA120 and Reason Code B7.
MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	

Code	Description	Notes
MA131	Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process the claim.	
MA132	Adjustment to the pre-demonstration rate.	
MA133	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.	
MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.	
N1	You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	Modified 2/28/03.
N2	This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.	
N3	Missing/incomplete/invalid consent form.	Modified 2/28/03.
N4	Missing/incomplete/invalid prior insurance carrier EOB.	Modified 2/28/03.
N5	EOB received from previous payer. Claim not on file.	
N6	Under FEHB Law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B.	Modified 2/28/03.
N7	Processing of this claim/service has included consideration under Major Medical provisions.	
N8	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.	
N9	Adjustment represents the estimated amount the primary payer may have paid.	
N10	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	Modified 10/31/02.
N11	Denial reversed because of medical review.	
N12	Policy provides coverage supplemental to Medicare. As member does not appear to be enrolled in Medicare Part B, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.	
N13	Payment based on professional/technical component modifier(s).	
N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	
N15	Services for a newborn must be billed separately.	
N16	Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.	
N17	Per admission deductible.	Deactivated effective 8/1/04. Use Reason Code 1.

Code	Description	Notes
N18	Payment based on the Medicare allowed amount.	Deactivated effective 1/31/04. Refer to N14.
N19	Procedure code incidental to primary procedure.	
N20	Service not payable with other service rendered on the same date.	
N21	Range of dates separated onto single lines.	
N22	This procedure code was added/changed because it more accurately describes the services rendered.	Modified 10/31/02, 2/28/03.
N23	Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.	Modified 8/13/01.
N24	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.	Modified 2/28/03.
N25	This company has been contracted by the provider's benefit plan to provide administrative claims payment services only. This company does not assume financial risk or obligation with respect to claims processed on behalf of your benefit plan.	
N26	Missing/incomplete/invalid itemized bill.	Modified 2/28/03.
N27	Missing/incomplete/invalid treatment number.	Modified 2/28/03.
N28	Consent form requirements not fulfilled.	
N29	Missing/incomplete/invalid documentation/orders/notes/ summary/report/invoice.	Modified 2/28/03.
N30	Patient ineligible for this service.	Modified 6/30/03.
N31	Missing/incomplete/invalid prescribing/referring/attending provider license number.	Modified 2/28/03.
N32	Claim must be submitted by the provider who rendered the service.	Modified 6/30/03.
N33	No record of health check prior to initiation of treatment.	
N34	Incorrect claim form for this service.	
N35	Program integrity/utilization review decision.	
N36	Claim must meet primary payer's processing requirements before Medicare can consider payment.	
N37	Missing/incomplete/invalid tooth number/letter.	Modified 2/28/03.
N38	Missing/incomplete/invalid place of service.	Modified 2/28/03.
N39	Procedure code is not compatible with tooth number/letter.	
N40	Missing/incomplete/invalid X-ray.	Modified 2/28/03, 6/30/03, 2/1/04.
N41	Authorization request denied.	Deactivated effective 10/16/2003. Refer to Reason Code 39.
N42	No record of mental health assessment.	
N43	Bed hold or leave days exceeded.	

Code	Description	Notes
N44	Payer's share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority.	Deactivated effective 10/16/2003. Refer to Reason Code 137.
N45	Payment based on authorized amount.	
N46	Missing/incomplete/invalid admission hour.	
N47	Claim conflicts with another inpatient stay.	
N48	Claim information does not agree with information received from other insurance carrier.	
N49	Court ordered coverage information needs validation.	
N50	Missing/incomplete/invalid discharge information.	Modified 2/28/03.
N51	Electronic interchange agreement not on file for provider/submitter.	
N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	
N53	Missing/incomplete/invalid point of pick-up address.	Modified 2/28/03.
N54	Claim information is inconsistent with pre-certified/authorized services.	
N55	Procedures for billing with group/referring/performing providers were not followed.	
N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	Modified 2/28/03.
N57	Missing/incomplete/invalid prescribing/dispensed date.	Modified 2/28/03.
N58	Missing/incomplete/invalid patient liability amount.	Modified 2/28/03.
N59	Provider should refer to their provider manual for additional program and provider information.	
N60	A valid NDC is required for payment of drug claims effective October 2002.	Deactivated effective 1/31/04. Refer to M119.
N61	Rebill services on separate claims.	
N62	Inpatient admission spans multiple rate periods. Resubmit separate claims.	
N63	Rebill services on separate claim lines.	
N64	The “from” and “to” dates must be different.	
N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	Modified 2/28/03.
N66	Missing/incomplete/invalid documentation.	Modified 2/28/03.
N67	Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you that the patient was excluded from this demonstration; or if you furnished these services in another location on the date of the patient's admission or discharge from a demonstration hospital. If services were furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.	

Code	Description	Notes
N68	Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment made to the facility. You must contact the facility for payment. Prior payment made to you by the patient or another insurer for this claim must be refunded to the payer within 30 days.	
N69	Prospective Payment System (PPS) code changed by claims processing system. Insufficient visits or therapies.	Modified 6/30/03.
N70	Home health consolidated billing and payment applies.	Modified 2/28/02.
N71	Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims.	Modified 2/21/02, 6/30/03.
N72	Prospective Payment System (PPS) code changed by medical reviewers. Not supported by clinical records.	Modified 6/30/03.
N73	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.	Modified 7/24/01, 2/28/03. Deactivated effective 1/31/04. Refer to MA101 and N200.
N74	Resubmit with multiple claims, each claim covering services provided in only one calendar month.	
N75	Missing/incomplete/invalid tooth surface information.	Modified 2/28/03.
N76	Missing/incomplete/invalid number of riders.	Modified 2/28/03.
N77	Missing/incomplete/invalid designated provider number.	Modified 2/28/03.
N78	The necessary components of the child and teen checkup (EPSDT) were not completed.	
N79	Service billed is not compatible with patient location information.	
N80	Missing/incomplete/invalid prenatal screening information.	Modified 2/28/03.
N81	Procedure billed is not compatible with tooth surface code.	
N82	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.	
N83	No appeal rights. Adjudicative decision based on the provisions of a demonstration project.	
N84	Further installment payments forthcoming.	
N85	Final installment payment.	
N86	A failed trial of pelvic muscle exercise training is required in order for biofeedback training for the treatment of urinary incontinence to be covered.	
N87	Home use of biofeedback therapy is not covered.	
N88	This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under a HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under a HHA episode of care.	

Code	Description	Notes
N89	Payment information for this claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.	
N90	Covered only when performed by the attending physician.	
N91	Services not included in the appeal review.	
N92	This facility is not certified for digital mammography.	
N93	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.	
N94	Claim/Service denied because a more specific taxonomy code is required for adjudication.	
N95	This provider type/provider specialty may not bill this service.	New code 7/31/01, Modified 2/28/03.
N96	Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.	New code 8/24/01.
N97	Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement) which are associated with secondary manifestations of the above three indications are excluded.	New code 8/24/01.
N98	Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50% or greater improvement through test stimulation. Improvement is measured through voiding diaries.	New code 8/24/01.
N99	Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.	New code 8/24/01.
N100	Prospective Payment System (PPS) code corrected during adjudication.	New code 9/14/01. Modified 6/30/03.
N101	Additional information is needed in order to process this claim. Please resubmit the claim with the identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters “HSP” and entered into item #32 on the claim form. You may bill only one site of service provider number per claim.	New code 10/16/01. Deactivated effective 1/31/04. Refer to MA105.
N102	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	New code 10/31/01.
N103	Social Security records indicate that this beneficiary was a prisoner when the service was rendered. This payer does not cover items and services furnished to beneficiaries while they are in state or local custody under a penal authority, unless under state or local law, the beneficiary is personally liable for the cost of his or her	New code 12/05/01. Modified 4/8/02, 2/28/03, 6/30/03.

Code	Description	Notes
N103 (con't)	health care while incarcerated and the state or local government pursues such debt in the same way and with the same vigor as any other debt.	
N104	This claim/service is not payable under the our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at http://www.cms.hhs.gov.	New code 1/29/02, Modified 10/31/02.
N105	This is a misdirected claim/service for an RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.	New code 1/29/02.
N106	Payment for services furnished to SNF inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.	New code 1/31/02.
N107	Services furnished to Skilled Nursing Facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services.	New code 1/31/02.
N108	Missing/incomplete/invalid upgrade information.	Modified 2/28/03.
N109	This claim was chosen for complex review and was denied after reviewing the medical records.	New Code 2/26/02.
N110	This facility is not certified for film mammography.	New Code 2/28/02.
N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	New Code 2/28/02.
N112	This claim is excluded from your electronic remittance advice.	New Code 2/28/02.
N113	Only one initial visit is covered per physician, group practice, or provider.	New Code 4/16/02. Modified 6/30/03.
N114	During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.	New Code 5/30/02.
N115	This decision was based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.hhs.gov/mcd, or if you do not have Web access, you may contact the contractor to request a copy of the LMRP.	New Code 6/26/02. Modified 9/16/02, 6/30/03.
N116	This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will	New Code 6/30/02.

Code	Description	Notes
N116 (con't)	need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.	
N117	This service is paid only once in a patient's lifetime.	New Code 7/30/02. Modified 6/30/03.
N118	This service is not paid if billed more than once every 28 days.	New Code 7/30/02
N119	This service is not paid if billed once every 28 days, and the patient has spent five or more consecutive days in any inpatient or Skilled Nursing Facility (SNF) within those 28 days.	New Code 7/30/02. Modified 6/30/03.
N120	Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/readmitted during payment episode.	New Code 8/9/02. Modified 6/30/03.
N121	No coverage or items or services provided by this type of practitioner for patients in a Skilled Nursing Facility (SNF) stay.	New Code 9/9/02. Modified 6/30/03.
N122	Mammography add-on code cannot be billed by itself.	New Code 9/12/02.
N123	This is a split service and represents a portion of the units from the originally submitted service.	New Code 9/24/02.
N124	Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.	New Code 9/26/02.
N125	Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The law permits refund requirement exceptions in two cases: ❖ If you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service/item; or ❖ If you notified the beneficiary in writing before providing it that Medicare likely would deny the service/item, and the beneficiary signed a statement agreeing to pay. If an exception applies to you or you believe the carrier was wrong in denying payment, you should request review of this determination by the carrier within 30 days of receiving this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30 days, you may delay refunding to the beneficiary until you have received the results of the review. If the review determination is favorable to you then you do not have to make any refund. If the	New Code 9/26/02.

Code	Description	Notes
N125 (con't)	review is unfavorable, you must make the refund within 15 days of receiving the unfavorable review decision. You may request review of the determination at any time within 120 days of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he or she may be entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days. The requirements for refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare Program. If you have any questions about this notice, please contact Medicare.	
N126	Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who have been deported.	New Code 10/17/02.
N127	This is a misdirected claim/service for a United Mine Workers of America beneficiary. Submit paper claims to: UMWA Health and Retirement Funds, PO Box 389, Ephraim, UT 84627-0361. Call Envoy at 1-800-215-4730 for information on electronic claims submission.	New Code 10/31/02.
N128	This amount represents the prior to coverage portion of the allowance.	New Code 10/31/02.
N129	This amount represents the dollar amount not eligible due to the patient's age.	New Code 10/31/02.
N130	Consult plan benefit documents for information about restrictions for this service.	New Code 10/31/02.
N131	Total payments under multiple contracts cannot exceed the allowance for this service.	New Code 10/31/02.
N132	Payments will cease for services rendered by this U.S. Government-debarred or excluded provider after the 30 day grace period as previously notified.	New Code 10/31/02.
N133	Services for predetermination and services requesting payment are being processed separately.	New Code 10/31/02.

Code	Description	Notes
N134	This represents the provider's scheduled payment for this service. If treatment has been discontinued, please contact Customer Service.	New Code 10/31/02.
N135	Record fees are the patient's responsibility and limited to the specified co-payment.	New Code 10/31/02.
N136	To obtain information on the process to file an appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548.	New Code 10/31/02.
N137	You, the provider, acting on the Member's behalf, may file an appeal with Medicare. You, the provider, acting on the Member's behalf, may file a complaint with the Commissioner in the State of Maryland without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The Commissioner's address: Commissioner Steven B. Larsen, Maryland Insurance Administration, 525 St. Paul Place, Baltimore, MD 21202 - (410) 468-2000.	New Code 10/31/02. Modified 2/28/03.
N138	In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review.	New Code 10/31/02
N139	Under the Code of Federal Regulations, Chapter 32, Section 199.13, a non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.	New Code 10/31/02.
N140	You have not been designated as an authorized OCONUS provider, therefore are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.	New Code 10/31/02.
N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.	New Code 10/31/02.
N142	The original claim was denied. Resubmit a new claim, not a replacement claim.	New Code 10/31/02.
N143	The patient was not in a hospice program during all or part of the service dates billed.	New Code 10/31/02.
N144	The rate changed during the dates of service billed.	New Code 10/31/02.

Code	Description	Notes
N145	Missing/incomplete/invalid provider identifier for this place of service.	New Code 10/31/02.
N146	Missing/incomplete/invalid/not approved screening document.	New Code 10/31/02.
N147	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.	New Code 10/31/02.
N148	Missing/incomplete/invalid date of last menstrual period.	New Code 10/31/02.
N149	Rebill all applicable services on a single claim.	New Code 10/31/02.
N150	Missing/incomplete/invalid model number.	New Code 10/31/02.
N151	Telephone contact services will not be paid until the face-to-face contact requirement has been met.	New Code 10/31/02.
N152	Missing/incomplete/invalid replacement claim information.	New Code 10/31/02.
N153	Missing/incomplete/invalid room and board rate.	New Code 10/31/02.
N154	This payment was delayed for correction of provider's mailing address.	New Code 10/31/02.
N155	Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.	New Code 10/31/02.
N156	The patient is responsible for the difference between the approved treatment and the elective treatment.	New Code 10/31/02.
N157	Transportation to and from this destination is not covered.	New Code 2/28/03.
N158	Transportation in a vehicle other than an ambulance is not covered.	New Code 2/28/03.
N159	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.	New Code 2/28/03.
N160	The beneficiary/patient must choose an option before this procedure/equipment/supply/service can be covered.	New Code 2/28/03.
N161	This drug/service/supply is covered only when the associated service is covered.	New Code 2/28/03.
N162	This is an alert. Although your claim was paid, you have billed for a test/specialty not included in your Laboratory Certification. Your failure to correct the Laboratory Certification information will result in a denial of payment in the near future.	New Code 2/28/03.
N163	Medical record does not support code billed per the code definition.	New Code 2/28/03.
N164	Transportation to/from this destination is not covered.	Deactivated effective 1/31/04. Refer to N157.
N165	Transportation in a vehicle other than an ambulance is not covered.	Deactivated effective 1/31/04. Refer to N158.
N166	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.	Deactivated effective 1/31/04. Refer to N159.
N167	Charges exceed the post-transplant coverage limit.	New Code 2/28/03

Code	Description	Notes
N168	The beneficiary must choose an option before a payment can be made for this procedure/equipment/supply/service.	Deactivated effective 1/31/04. Refer to N160.
N169	This drug/service/supply is covered only when the associated service is covered.	Deactivated effective 1/31/04. Refer to N161.
N170	A new/revised/renewed certificate of medical necessity is needed.	New Code 2/28/03.
N171	Payment for repair or replacement is not covered or has exceeded the purchase price.	New Code 2/28/03.
N172	The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item.	New Code 2/28/03.
N173	No qualifying hospital stay dates were provided for this episode of care.	New Code 2/28/03.
N174	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group “PR”.	New Code 2/28/03.
N175	Missing/incomplete/invalid Review Organization Approval.	New Code 2/28/03.
N176	Services provided aboard a ship are covered only when the ship is of U.S. registry and is in U.S. waters. In addition, a doctor licensed to practice in the U.S. must provide the service.	New Code 2/28/03.
N177	We did not send this claim to beneficiary's other insurer. They have indicated no additional payment can be made.	New Code 2/28/03.Modified 6/30/03.
N178	Missing/invalid/incomplete pre-operative photos or visual field results.	New Code 2/28/03.
N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.	New Code 2/28/03.
N180	This item or service does not meet the criteria for the category under which it was billed.	New Code 2/28/03.
N181	Additional information has been requested from another provider involved in the care of this member. The charges will be reconsidered upon receipt of that information.	New Code 2/28/03.
N182	This claim/service must be billed according to the schedule for this plan.	New Code 2/28/03.
N183	This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits.	New Code 2/28/03.
N184	Rebill technical and professional components separately.	New Code 2/28/03.
N185	Do not resubmit this claim/service.	New Code 2/28/03.
N186	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.	New Code 2/28/03.
N187	You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	New Code 2/28/03.

Code	Description	Notes
N188	The approved level of care does not match the procedure code submitted.	New Code 2/28/03.
N189	This service has been paid as a one-time exception to the plan's benefit restrictions.	New Code 2/28/03.
N190	Missing/incomplete/invalid contract indicator.	New Code 2/28/03.
N191	The provider must update insurance information directly with payer.	New Code 2/28/03.
N192	Patient is a Medicaid/Qualified Medicare Beneficiary.	New Code 2/28/03.
N193	Specific Federal/state/local program may cover this service through another payer.	New Code 2/28/03.
N194	Technical component not paid if provider does not own the equipment used.	New Code 2/28/03.
N195	The technical component must be billed separately.	New Code 2/28/03.
N196	Patient eligible to apply for other coverage which may be primary.	New Code 2/28/03.
N197	The subscriber must update insurance information directly with payer.	New Code 2/28/03.
N198	Rendering provider must be affiliated with the pay-to provider.	New Code 2/28/03.
N199	Additional payment approved based on payer-initiated review/audit.	New Code 2/28/03.
N200	The professional component must be billed separately.	New Code 2/28/03.
N201	A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents.	New Code 2/28/03.
N202	Additional information/explanation will be sent separately.	New Code 6/30/03.
N203	Missing/incomplete/invalid anesthesia time/units.	New Code 6/30/03.
N204	Services under review for possible pre-existing condition. Send medical records for prior 12 months.	New Code 6/30/03.
N205	Information processed was illegible.	New Code 6/30/03.
N206	The supporting documentation does not match the claim.	New Code 6/30/03.
N207	Missing/incomplete/invalid birth weight.	New Code 6/30/03.
N208	Missing/incomplete/invalid DRG code.	New Code 6/30/03.
N209	Missing/invalid/incomplete taxpayer identification.	New Code 6/30/03.
N210	You may appeal this decision.	New Code 6/30/03.
N211	You may not appeal this decision.	New Code 6/30/03.
N212	Charges processed under a Point of Service benefit.	New Code 2/1/04.